



Authorization for Release of Information

Patient name: _____ Date of birth: _____
Previous name: _____

I. My Authorization: I give my permission for the physician/entity listed below to disclose my health care information consistent with this authorization:

Doctor's Name: _____

Address: _____

City, State, Zip: _____

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____
- Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for the sensitive health information below (check all that apply). If none of the above boxes are checked, no information related to the testing, diagnosis or treatment of the categories below will be disclosed pursuant to this authorization. I understand that if I want to authorize your use or disclosure of this information later, I will be asked to sign another authorization.

- HIV (AIDS virus)
- Sexually transmitted diseases
- Psychiatric disorders/mental health
- Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization: Western Washington Medical Group - GI Dept
Address: 4225 Hoyt Ave, Ste A City: Everett State: WA Zip: 98203-
Phone: 425-259-3122 Fax: 425-252-9860

Reason(s) for this authorization (check all that apply):

- at my request
- other (specify) _____
- check only if for marketing purposes
- check only if WWMG will be paid or get something of value for providing health information for marketing purposes

This authorization ends: *(This document does not permit disclosure of health information created more than 90 days after the date it is signed.)*

- in 90 days from the date signed
- when the following event occurs: _____
(no longer than 90 days from date signed)
- on (date): _____

I understand that I may change my mind and decide to cancel my authorization to use and disclose my health care information at any time. I understand that if I choose to revoke my authorization, I need to do it in writing by sending a letter to the person or organization listed above. I also understand that if I cancel this authorization, the information may have already been used or disclosed before I changed my mind.

